REQUEST TO ACCESS PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number:_____

As a parent, guardian, or personal representative you have the right to request to inspect the Medi-Cal records of the individual you are authorized to represent. You also have the right to request copies of the records. You will be charged for the cost of copying and postage for some records. You will receive a response to your request within 30 days after we receive your request and payment. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license or other listed identification and documentation verifying your authority to represent the stated individual. You will also need to send documentation verifying your address, such as a utility bill displaying your address. Mail this completed form to:

Department of Health Services
EDS Communications
P. O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING		
LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY/STATE	ZIP CODE
BENEFICIARY ID NUMBER	DATE OF BIRTH	DATE OF DEATH (If applicable) DEATH CERTIFICATE MUST BE ATTACHED

DIRECTIONS

Please read the following before completing this form. If any of the conditions set out below apply to the beneficiary you are requesting information about, you do not need to fill out this form.

He/she has a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments, or

He/she is requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. He/she may have received an Estate Recovery Questionnaire in the mail, or

He/She is involved in a worker's compensation case in which Medi-Cal has paid for services for the injury he/she received while on the job.

To get information for a Medi-Cal beneficiary recovery case, please call (916) 650-0490.

If the beneficiary is a member of a Medi-Cal Managed Care Plan, please contact his/her plan for access to his/her medical records.

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?

☐ PARENT
☐ CONSERVATOR
☐ GUARDIAN
☐ EXECUTOR OF WILL
☐ MEDICAL POWER OF ATTORNEY
☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS
WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

☐ CLAIM DETAIL REPORTS, which show claims paid by Medi-Cal for services received. **($25 fee)**

☐ TREATMENT AUTHORIZATION REQUEST SCREENS. Printouts show which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision, and whether the provider has billed for these services. (No fee)

☐ CASE MANAGEMENT RECORDS, which show case manager notes. (No fee)

Managed Care Records:
- ☐ Enrollment Records
- ☐ Disenrollment Records
- ☐ Capitation Paid to Health Plan
- ☐ Complaint investigation files

(No fee)

Please contact your managed care plan if you want access to your medical records.

Other, please specify:

_____
_____
_____

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?

FROM DATE	TO DATE

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME:

TELEPHONE NUMBER: ( )

ADDRESS:

RELATIONSHIP TO YOU:

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.
LOCATION AVAILABLE FOR IN PERSON REVIEW: **SACRAMENTO ONLY**

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: _____

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE: DATE:

(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY _____ ON _____(DATE)

NOTARY PUBLIC NUMBER: _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.